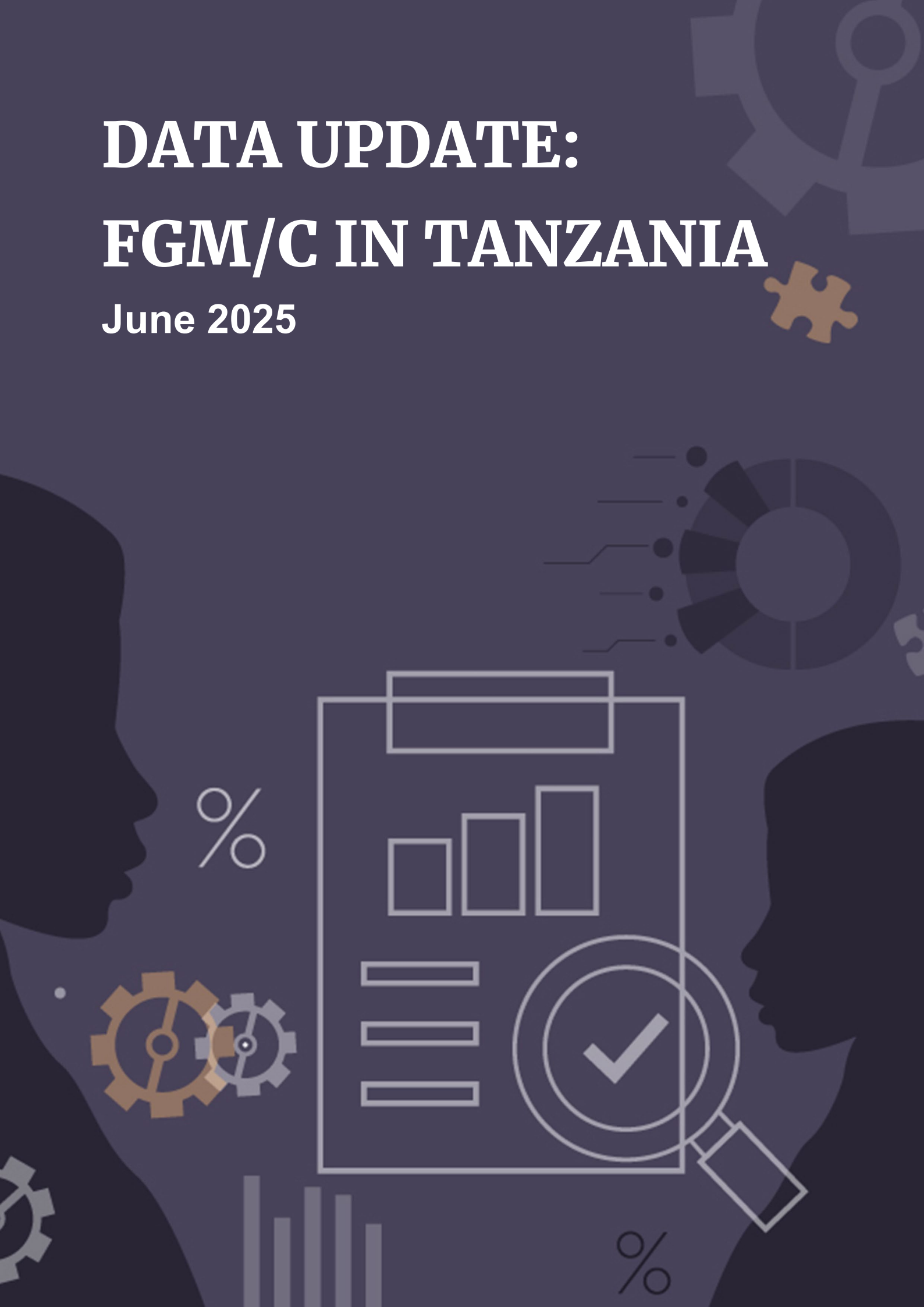
DATA UPDATE: FGM/C IN TANZANIA

June 2025



About Orchid Project

Orchid Project is a UK- and Kenya-based non-governmental organisation (NGO) catalysing the global movement to end female genital mutilation/cutting (FGM/C). Its strategy for 2023 to 2028 focuses on three objectives:

1. to undertake research, generate evidence and curate knowledge to better equip those working to end FGM/C;

2. to facilitate capacity-strengthening of partners, through learning and knowledge-sharing, to improve programme designs and impacts for the movement to end FGM/C; and

3. to steer global and regional policies, actions and funding towards ending FGM/C.

Orchid Project's aim to expedite the building of a knowledge base for researchers and activists is being fulfilled in the **FGM/C Research Initiative.**

About End FGM/C Network to Africa

The End FGM/C Network, Africa (African Network) is an African-led initiative providing a unified voice to influence decision-makers and drive coordinated advocacy to end Female Genital Mutilation/Cutting (FGM/C) across Africa. We are a network of civil society organizations dedicated to creating a sustainable movement to end FGM/C across the continent, similar to regional networks in Asia, North America, and Europe. https://endfgmafrica.org/

All cited texts in this data update were accessed between May and June 2025, unless otherwise noted.

A Note on Data

Data used in this data update report includes Demographic Health Surveys (DHS) from 1996, 2004-2005, 2010, 2015-2016, and 2022. There are no Multiple Indicator Cluster Surveys (MICS) for Tanzania that include data on FGM/C.

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WORKING TOGETHER TO END
FEMALE GENITAL CUTTING

Summary

Prevalence of FGM/C in Tanzania has decreased steadily between 1996 and 2022 from 17.9% (1) to 8.2% (2). Prevalence has reduced in both urban and rural areas with a drop from 20.3% in 1996 to 10.7% in 2022 in rural areas (1,2) and from 10.0% to 3.5% in urban areas. (1,2).

FGM/C is not uniformly practiced in Tanzania and there are significant variations by region. Within Zanzibar, less than 1% of women and girls have been cut compared to 9% of women and girls on the Mainland (2). When comparing data from 2015-16 and 2022, prevalence has decreased most notably among women aged 15-49 in Dodoma (46.7% to 17.6%) and Singida (30.9% to 19.8%) (3,2). It should be noted that in some regions, there have been increases in prevalence within this time period. These regions include Tanga (13.7% to 18.8%) and Iringa (7.5% to 12.1%) (3, 2).

Prevalence is still highest among women and girls with no education, compared to those with higher levels of education. In 2022, 16.0% of girls with no education had undergone FGM/C compared to 2.5% of girls who had completed secondary education (2). Prevalence is also highest among women and girls in the lowest wealth quintile with 19.6% of girls in this quintile having been cut while contrarily, only 3.1% of girls in the highest wealth quintile having undergone FGM/C (2).

89.2% of girls are cut with flesh removed. 55% are cut by a traditional birth attendant and 26% by a traditional cutter (2). The age of cutting varies widely with 33.9% of girls cut before the age of 5, 28.2% cut between the ages of 10-14; and 20.0% cut after the age of 14 (2). These figures indicate that girls in Tanzania often undergo the practice at an extremely young age. This factor has implications for programming and policy and must be considered when designing effective prevention strategies.

There is overwhelming attitudinal support for the abandonment of FGM/C within Tanzania, including 98% of women aged 15-49 opposing the continuation of the practice and 96% of men (2).

Update on FGM/C trends

Prevalence of FGM/C in Tanzania has decreased steadily between 1996 and 2002 from 17.9% (1) to 8.2% (2). Prevalence has reduced in both urban and rural areas with a drop from 20.3% in 1996 to 10.7% in 2022 in rural areas (1,2) and from 10.0% to 3.5% in urban areas. (1,2).

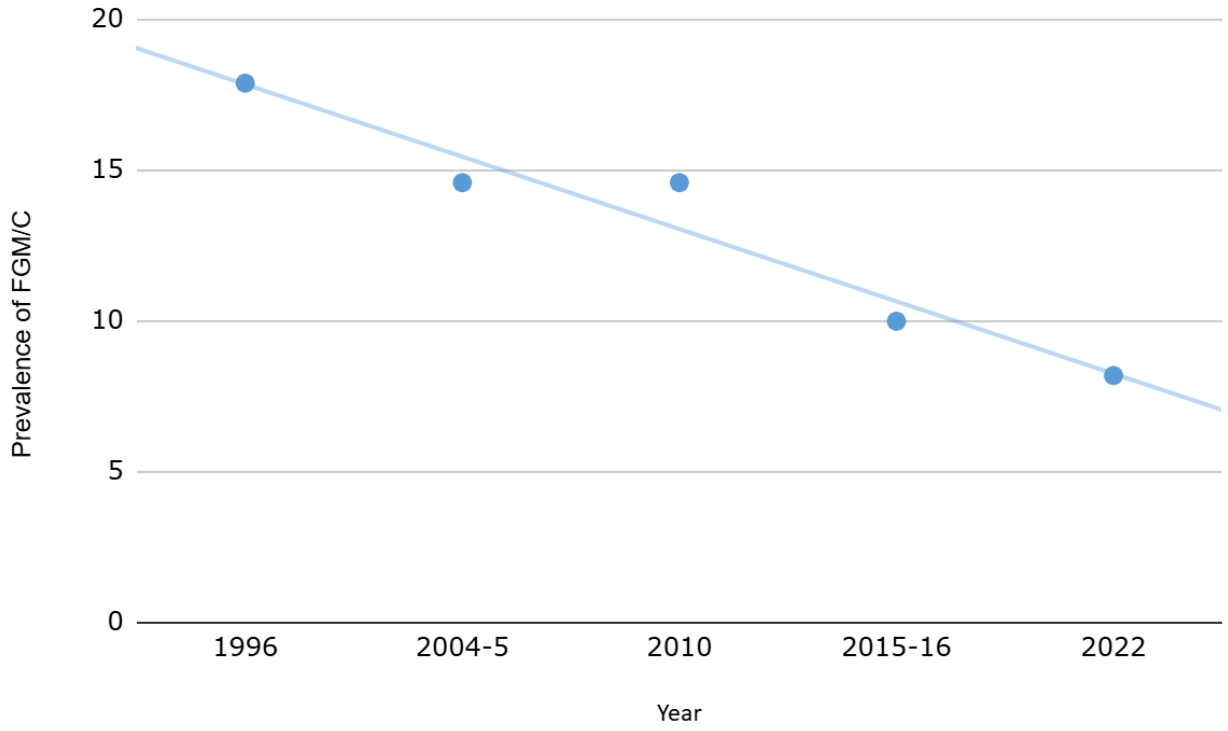
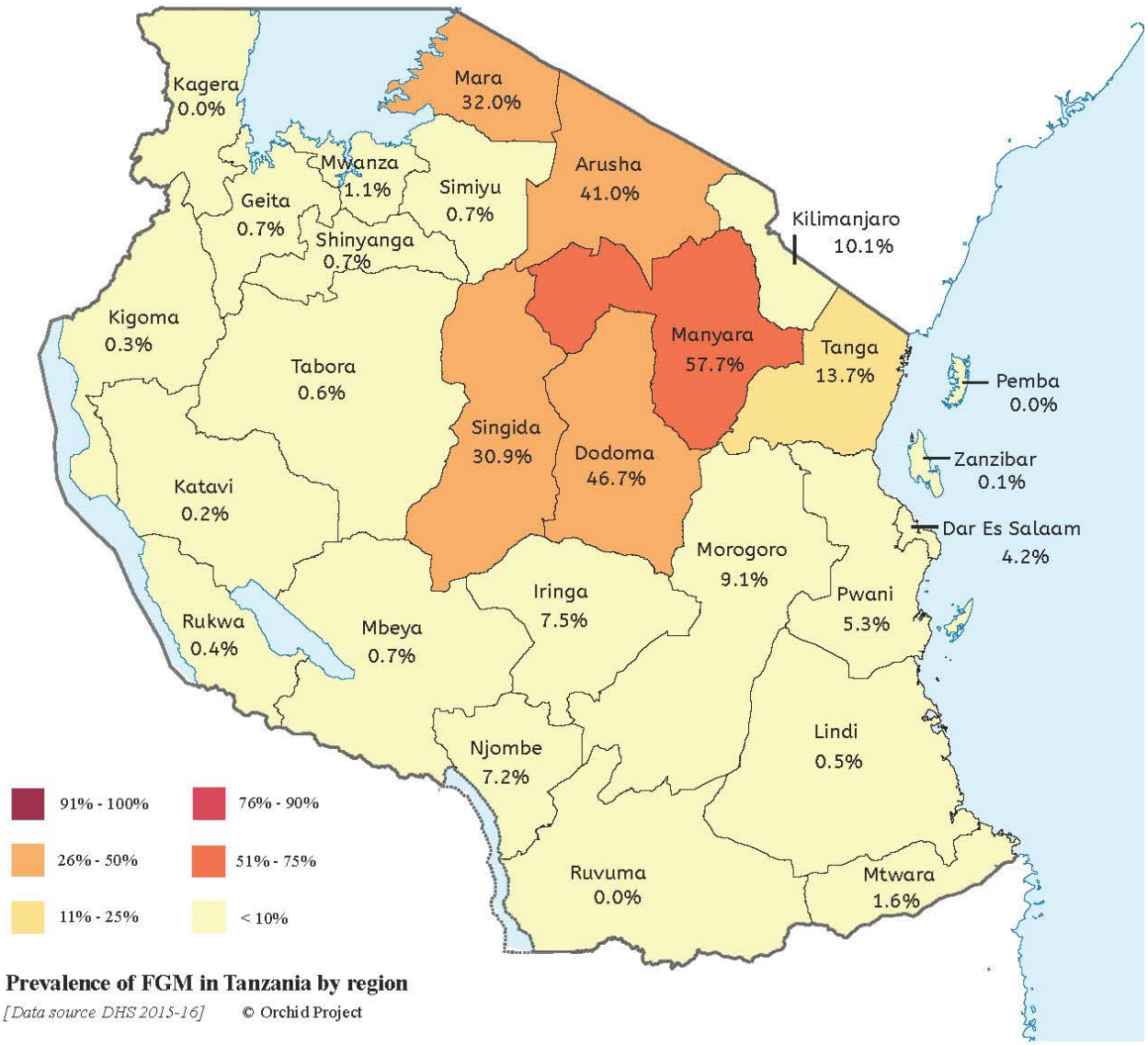


Figure 1: Prevalence of FGM/C among Tanzanian women aged 15-49 years (1996, 2004-5, 2010, 2015-16, 2022)

Prevalence of FGM/C has decreased in several regions of Tanzania between 2015-16 and 2022, predominantly Dodoma, Singida, and Manyara. However, prevalence of FGM/C has increased in the regions of Iringa and Tanga, and stayed mostly the same in Mara and Arusha.



Prevalence of FGM in Tanzania by region

[Data source DHS 2015-16] © Orchid Project

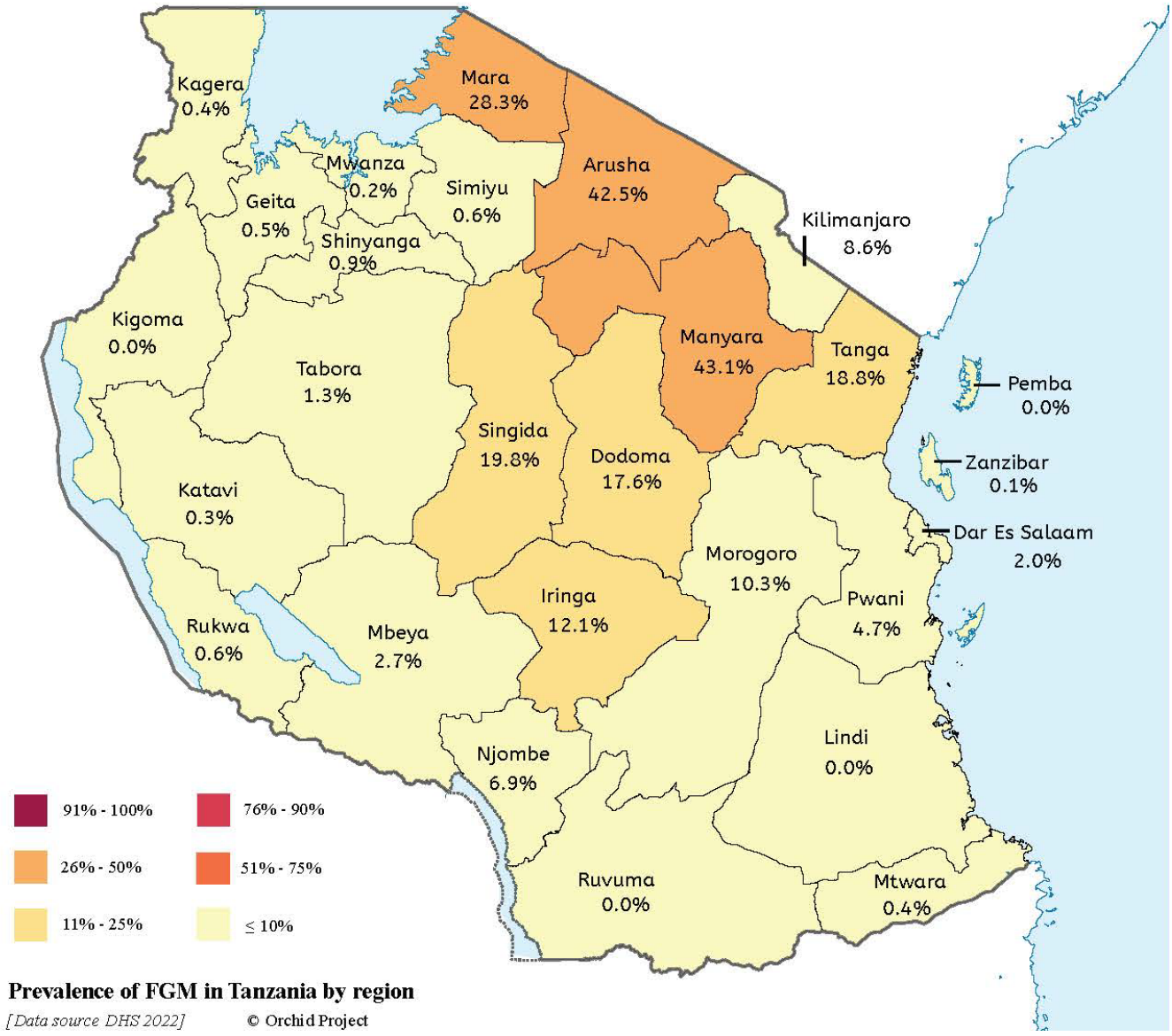


Figure 2: Prevalence of FGM/C among Tanzanian women aged 15-49 years by region (2015-16, 2022)

Changes in type of cutting

The most common type of cutting is 'cut, flesh removed' which was reported by 81.1% of women aged 15-49 in 2015-16 (3) and by 89.2% of women of the same age group in 2022 (2).

While FGM/C has been historically performed by designated 'traditional cutters', only 26% of girls are cut by a 'traditional cutter' whereas 55% of girls are cut by a traditional birth attendant (2).

Type of cutting varies by region, which has links to variations in ethnic groups. Partial or total removal of the clitoris is most common in Kilimanjaro, Arusha, Iringa, Mtwara, Kilosa, and Tarime (4). Partial or total removal of the labia minora is common in Kilimanjaro, Arusha, Iringa, and Mtwara. Infibulation is practiced primarily by immigrants from Somalia and those from the Nubian ethnic group in the Kilimanjaro and Arusha regions (4). In Tanzania, there are also other types of cutting which do not align with the World Health Organization (WHO) classifications or within the DHS module questions on FGM/C. These types include use of corrosive substances and herbs within the vagina for the purpose of tightening, and what is known in Swahili as 'kuvuta matunya' - a process of elongating the labia with the belief that this will enhance pleasure for men (4).

Ethnicity and FGM/C

Tanzania is a country made up of over 120 ethnic groups and ethnicity has a significant influence on the practice of FGM/C. However, data on ethnicity and FGM/C is not collected within the DHS and there is minimal academic research on the intersection of ethnicity and the practice in Tanzania. This is largely driven by political motives and reflects a national framework promoting unity within the country, which includes an avoidance of data collection highlighting variations between ethnic groups/ tribes, even within the national census (5).

However, when overlaying prominent ethnicities in different regions of Tanzania with the prevalence maps, and with use of qualitative data, it is possible to identify practicing ethnic groups.

FGM/C is most prevalent within Mara, Dodoma, Singida, Tanga, Morogoro, Iringa and Kilimanjaro. However, prevalence varies within these regions by ethnicity and is most commonly practiced by Kuria, Maasai, Gogo, Nyaturu, Pare, and Hadza ethnic groups (4).

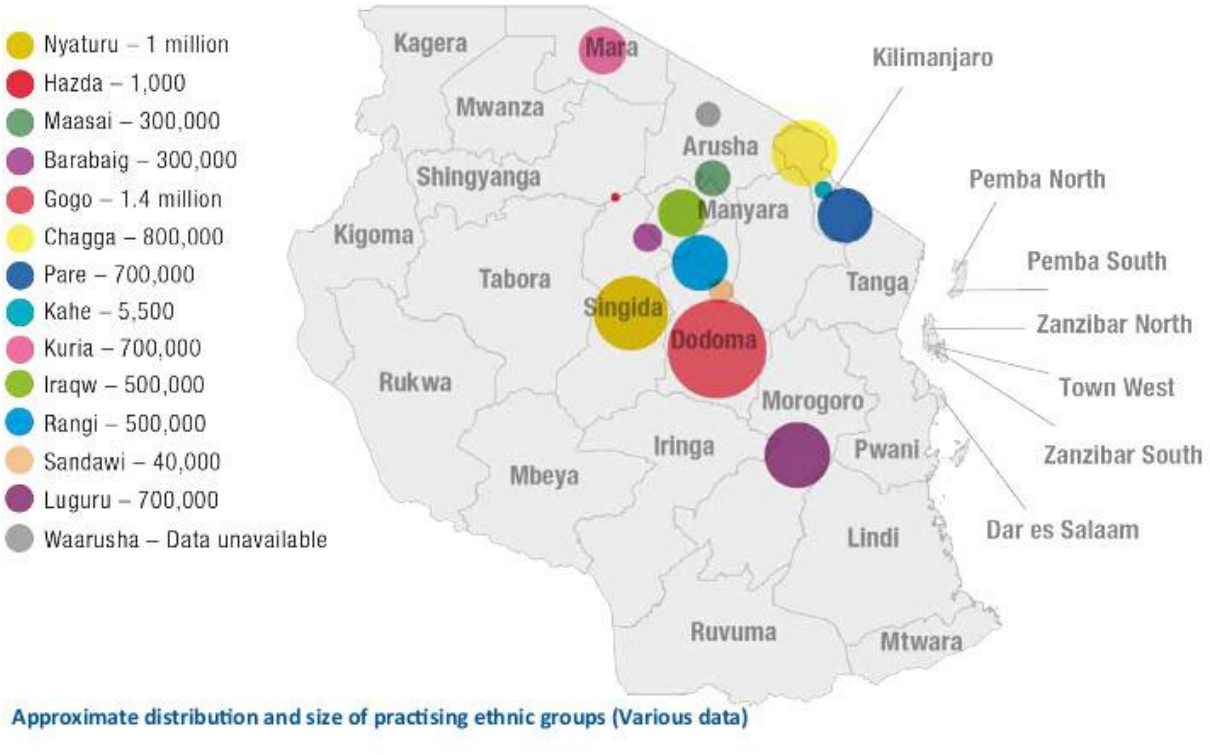


Figure 3: Approximate distribution and size of practising ethnic groups (5)

Changes in attitudes toward FGM/C

There is overwhelming support for the end of FGM/C in Tanzania. Of those who have been cut, support for the practice has reduced from 13.2% in 2015-16 to 10.3% in 2022 (3, 2). Among women and girls who have not been cut, those who believe FGM/C should not be continued have increased from 96.4% in 2015-16 to 99% in 2022 (3, 2). This data suggests that there is increasing support for the abandonment of FGM/C, including from women who have undergone the cut and those who have not.

The practice of FGM/C has deep-seated roots in cultural traditional and harmful long-standing societal expectations. FGM/C is a practice that is perceived to be inherited from elders. It is practiced to control sexual desire for women, especially when their husband travels and is away from home for a long time. Some groups believe that if a girl is uncircumcised, she is cursed and that this can have negative consequences for her husband and children (6). Some groups believe that FGM/C will protect again lawalawa, which is a type of vaginal or urinary tract infection (7).

Update on context

Politics

The current political context in Tanzania is tense as the country approaches elections in October 2025. Marked by calls for electoral reform and opposition mistrust, the country's current political climate is shaped by President Samia Suluhu Hussan, who took over leadership of the country after the death of Dr. John Pombe Magufuli in 2021.

The leading opposition party, Chadema, has refused to participate in the upcoming elections unless there is electoral reform (8, 9). After the 2020 elections, Tundu Lissu, the former Chadema party leader and presidential candidate, accused the ruling party, Chama cha Mapinduzi (CCM), of election tampering and deemed the electoral commission ineffective (10). In local elections in November 2024, many opposition party candidates were disqualified and CCM won 99% of parliamentary seats (11).

Tundu Lissu is currently on trial for treason, a crime punishable by death (12). In 2017, Lissu sustained injuries when his vehicle was shot at and he lived in self-imposed exile until returning to Tanzania in 2023 (13). Chadema claim that over 100 of their members have been detained, many disappeared, and some killed (13).

How the election will unfold depends on the leadership of current President Samia Suluhu Hussan to maintain civic space, uphold civil liberties, and commit to transparency in the upcoming elections.

Development

Tanzania is a country of over 67 million people consisting of over 120 ethnic groups (14). 26.4% of Tanzanians live below the poverty line (14).

Tanzania has made progress on several development indices, including the Human Development Index (HDI), Gender Development Index, Multi Poverty Index, and Gender Inequality Index, and has experienced a change in HDI score from 0.371 in 1990 to 0.549 in 2021 (15).

FGM/C and the Law

FGM/C is against the law in Tanzania and part of the Sexual Offences Special Provision Act of 1998 (16). The Sexual Offences Special Provision Act inserted a new section into the Penal Code, Section 169(A) which states that,

> (l) Any person who, having the custody, charge or care of any person under eighteen years of age, ill treats, neglects or abandons that person or causes female genital mutilation or procures that person to be assaulted, ill treated, neglected or abandoned in a manner likely to, cause him suffering or injury to health, including injury to, or loss, of sight or hearing, or limb or organ of the body or any mental derangement, commits the offence of cruelty to children (16).

In addition, the Law of the Child Act 2009 protects persons under the age of 18, and Article 13(1) makes it a criminal offence to 'subject a child to torture, or other cruel, inhuman punishment or degrading treatment including any cultural practice which dehumanizes or is injurious to the physical and mental well-being of a child' (17). Yet, despite the legal prohibition of FGM/C in Tanzania, there remains a gap between national policy and local enforcement.

Update on research

Impact of FGM/C on educational attainment

A study conducted by Pesambili and Mkumbo in 2018 explored the long-term impacts of FGM/C on the wellbeing of girls through a qualitative study in Tarime, Tanzania (18). The study found that the effects of FGM/C are multifaceted and include increased risk of early marriage, decreased interest in education and schooling among girls, and poor educational achievement. Additionally, girls who are not cut experience stigma and isolation from their peers. The study found that while there was widespread awareness of the negative consequences of FGM/C within Tarime, cultural, social, and economic factors continue to fuel and sustain the practice despite this knowledge.

FGM/C as a precursor to child marriage in Tanzania

Four out of ten girls in Tanzania are married before their 18th birthday. In a study conducted by Human Rights Watch, for some ethnic groups, such as the Maasai and Gogo, FGM/C is closely linked to child marriage — often performed between the ages of 10-15 years as a rite of passage to prepare for marriage (19). Marriage of daughters has economic incentives for families as the practice of dowry (payment by the groom to the bride's family) is widespread. The study found that many girls view marriage as a way to escape poverty, violence, or family neglect, perpetuating both early marriage and FGM/C as its precursor.

FGM/C as cultural inheritance

In a study by Mkuwa et al. in 2023 (6), the role of key change agents in ending FGM/C was explored. The practice is primarily seen to be inherited from elders with various driving beliefs behind the inheritance. Some people believe that FGM/C reduces women's sexual desire, and this was seen to be important for husbands who have to be away from home often. In some communities, uncircumcised girls are seen as cursed which was believed to bring negative consequences to husbands and children. The study's authors recommend engaging with tribal/community leaders to challenge myths and misconceptions about the practice, as well as promoting inter-tribal marriage to increase exposure to non-practicing communities.

Evaluating the impact of public health education campaigns among Maasai

A study was conducted in 2015 by Galukande et al. (20) to assess the impact of an 18-month long campaign against FGM/C among the Maasai community in Tanzania. The campaign used a behaviour risk reduction approach, treating FGM/C as a public health threat. At endline, self-reported FGM/C was 69.2%, however obstetric examination of women in labour revealed a prevalence of over 95%. While the campaign had some influence on knowledge of health risks, with an increase from 16% to 30%, it was not possible to measure a change in FGM/C prevalence. The variation between self-reported prevalence and obstetric examination reveals a critical obstacle to FGM/C data collection - underreporting of the practice.

The changing role of traditional birth attendants in Tanzania

In an ethnographic study conducted in 2021 by Shimpuku et al (21) in Usadawe, Tanzania, the author explored the changing role of traditional birth attendants in Tanzania and the historical context surrounding their work. The role of traditional birth attendant emerged after the WHO Alma Ata declaration in 1978 (21). However, the Ministry of Health in Tanzania has struggled to reduce maternal mortality with a number of women preferring to give birth at home with traditional birth attendants. Introducing community health workers has been an attempt to alleviate this challenge but in order to avoid sidelining traditional birth attendants, this group has been brought into training for the purpose of shifting their role toward health facility accompaniment and health education.

Recommendations

1. As the age of cutting in Tanzania varies depending on ethnicity, this has important implications for programming. Programming must be adapted to the local context and take into consideration the variations in age of cutting.

According to UNFPA, the following recommendations are made for programmatic interventions based on age of cutting (22):

a) As 33.9% of girls are cut before the age of 5 (2) and where risk is elevated before the age of 5, UNFPA recommends:
   i) Mobilizing communities by engaging influential persons (religious leaders, community elders and others based on the local context) and wider community representatives.
   ii) Conducting community network analysis and creating a referral pathway between health facilities or midwives at community levels and women's support groups and community-based organizations.
   iii) Targeting mothers during antenatal, delivery and postnatal care.
   iv) Using women's groups for education, dialogue and support.
   v) Using child survival programmes (particularly immunization) for outreach
   vi) Engaging fathers (whenever the opportunity exists) and grandmothers.

a) 28.2% of girls are cut between the ages of 10-14 years and 20.0% are cut after the age of 14 (2). Where risk is elevated during the ages of 10-18, UNFPA recommends:
   i) Girls' empowerment initiatives targeting both in- and out-of-school girls (clubs, peer group approach, life skills, alternative rites of passage programmes, etc.).
   ii) Protection and service provision (to protect girls who stand up against the practice and/or run away from their homes).
   iii) Provision of shelters – sustainable protection mechanisms.
   iv) Facilitating access to justice. Have helpline (for accessing information and reporting cases).
   v) Creating safe spaces.
   vi) Mobilizing communities by engaging influential persons (religious leaders, community elders and others based on the local context) and wider community representatives.

vii) School interventions (including integration of female genital mutilation topics into secondary school curriculum, establishment of guidance and counselling units in schools etc.).

2. Research indicates that there may be underreporting of prevalence in Tanzania (20). This could be linked to fear of prosecution or social desirability bias in research. It is important for researchers, practitioners and policymakers to assume that the actual prevalence may be higher than what is reported in studies and what the DHS data shows. Using indirect questioning techniques in research may help to avoid social desirability bias in reported prevalence figures (23).
3. As there are a number of misconceptions and false beliefs around FGM/C in Tanzania, it is critical to work with ethnic/ tribal leaders, as well as community elders to shift these beliefs and to promote these leaders as changemakers within their communities (beliefs about lawalawa (vaginal/ urinary tract infection), curses, control of sexual desire through FGM/C). As a number of these beliefs centre on the experiences and/ or fears of men (i.e. controlling sexual desire of a wife while the husband is away from home or avoid curses for the family), engaging men and boys in rethinking these beliefs is essential to the eradication of FGM/C in Tanzania.
4. In Tanzania, 55% of girls are cut by traditional birth attendants (2). As the Ministry of Health are already working to change the role of traditional birth attendants toward health education and birth accompaniment, it is critical that the issue of FGM/C is also addressed within training of this service cadre.

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